Hospital Letterhead

Hospital ABN 1.

_____
Date of Notice

_____ _____
Name of Patient Admission Date

_____ _____
Address Health Insurance Claim (HIC) Number

_____ _____
City, State, Zip Code Attending Physician's Name

YOUR IMMEDIATE ATTENTION IS REQUIRED

Dear _____: (*Insert the name of the addressee.*)

The purpose of this notice is to inform you that we find that your admission for *(specify services or condition)* is not covered under Medicare because *(specify services to be furnished or condition to be treated) (specify is/are medically unnecessary)* or *(could be safely furnished in another setting)* This determination was based upon our understanding and interpretation of available Medicare coverage policies and guidelines. You should discuss with your attending physician other arrangements for any further health care you may require. If you decide to *(be admitted to/remain in)* the hospital, you will be financially responsible for _____.1/

This notice, however, is not an official Medicare determination. The *(name of QIO)* is the Quality Improvement Organization (QIO) authorized by the Medicare program to review inpatient hospital services provided to Medicare patients in the State of *(name of State)*, and to make that determination.

- **If you disagree with our conclusion:** *(Select as appropriate)*

Preadmission:
Request **immediately**, but no later than 3 calendar days after receipt of this notice, or, if admitted, at any point in the stay, an immediate review of the facts in your case. You may make this request through us or directly to the QIO by telephone or in writing to the address listed below.

Admission:
Request **immediately**, or at any point during your stay, an immediate review of the facts in your case. You may make this request through us or directly to the QIO by telephone or in writing to the address listed below.

- **If you do not wish an immediate review:**

You may still request a review within 30 calendar days from the date of receipt of this notice by telephoning or writing to the address specified below.

- **Results of the QIO Review:**

The QIO will send you a formal determination of the medical necessity and appropriateness of your hospitalization, and will inform you of your reconsideration and appeal rights.

IF THE QIO DISAGREES WITH THE HOSPITAL (i.e., the QIO determines that your care is covered), you will be refunded any amount collected except for any applicable amounts for deductible, coinsurance, and convenience services or items normally not covered by Medicare.

IF THE QIO AGREES WITH THE HOSPITAL, you are responsible for payment for all services beginning on (*specify date*). 1/

- **QIO Address:**
  (QIO Name)
  (Address)
  (Telephone Number)

Sincerely,

_____

(*Title, e.g., Chairperson of Utilization Review Committee, Medical Staff, etc.*)

ACKNOWLEDGMENT OF RECEIPT OF NOTICE

This is to acknowledge that I received this notice of noncoverage of services from _____*Name of Hospital*_____ at _____*Time*_____ on _____*Date*_____. I understand that my signature below does not indicate that I agree with the notice, only that I have received a copy of the notice.

_____ _____ _____

Signature of patient or authorized representative Time Date

cc: QIO
Attending Physician

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1/ For preadmission notices, insert: "all customary charges for services furnished during the stay, except for those services for which you are eligible under Part B."
For admission notices issued not later than 3:00 P.M. on the date of admission, insert: "customary charges for all services furnished after receipt of this hospital notice, except for those services for which you are eligible under Part B." (If these requirements are not met, insert the liability phrase below.)
For admission notices issued after 3:00 P.M. on the day of admission, insert: "customary charges for all services furnished on the day following the day of receipt of this notice, except for those services for which you are eligible to receive payment under Part B."